FULTON/HIGHPOINT CHEVROLET

EMPLOYEE HEALTH PLAN BOOKLET

INTRODUCTION

Fulton/Highpoint Chevrolet, is committed to the well being and general good health of each employee and their dependents. To this end, we have designed a Group Health Benefit Program to meet the costs of proper health care.

The Company has retained the services of an Independent Plan Supervisor, experienced in claims processing, to handle health claims.

If you should incur expenses through a non preferred provider (PPO) for which you would like to claim benefits, contact your Benefits Administrator in Human Resources to obtain the necessary forms to be completed by your physician and yourself and submitted to the Plan Supervisor as described in the last page of this booklet. Always be sure to include itemized bills that adequately describe all services rendered.

This booklet is issued merely as a brief description of the coverage provided under the Plan. It should be understood that this booklet is not a contract and does not contain all the plan details. The provisions principally affecting you as described herein are subject to all the terms, conditions, and provisions of the Plan Document, which is on file with the Plan Administrator.

You are entitled to this coverage if you are eligible in accordance with the Plan Document. This booklet is void if you have ceased to be entitled to coverage. No clerical error will invalidate your coverage if otherwise validly in force.

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EMPLOYEE LIFE INSURANCE BENEFITS

ALL ELIGIBLE EMPLOYEES

US Benefits will provide a separate booklet concerning the Life Insurance Benefits.

SCHEDULE OF BENEFITS

	(In-Network) **Preferred Provider**		(Out-of-Network) **Regular Indemnity**
Calendar Year Deductible	-0-		$200 per person ($500 per family)
HOSPITAL BENEFITS	**Co-Pay**	**% Payable**	**% Payable**
Hospital In-Patient	$100*	100%	80%
Intensive Care	-----	100%	80%
Emergency Room/Out Patient	$50(waived if admitted)	100%	80%
Unreplaced blood,blood plasma	-----	100%	80%
Drugs and Medications (in Hospital)	-----	100%	80%
* (Annual Maximum of 3 co-pays or $300)			
Convalescent Home or Skilled Nursing Facility**			
Room & Board	$20 per day	100%	50% (based on semi-private room rate in Hospital)
**See page 16, item 14 for limitations and other restrictions.			
MAJOR MEDICAL BENEFITS	**Co-Pay**	**% Payable**	**% Payable**
Ambulance	---	100%	80%
Anesthesia Administration (per operation)	$10	100%	80%
Physicians Office or Hospital Visits	$10	100%	80%
Specialist Consultations (see page 24)	$10	100%	80%
Surgery in Hospital	$100	100%	80%
Surgeon (Pre & Post Operation Visits)	$10	100%	80%
Additional Medical Services			
Allergy Testing (per visit)(see page 17)	$10	100%	Not Covered
Chemotherapy and Radiation (per visit)	$10	100%	80%
Diagnostic Lab & X-ray (per visit)	$10	100%	80%
Home Health Care (see page 19)	$10	100%	80%
Hospice Care (see page 18)	---	90%	90%
Immunization & Injections (per visit)	$10	100%	80%
Mammography Screening (see page 17)	$10	100%	80%
Routine Health Exams (see page 18)	$10	100%	Not Covered
Physical & Speech Therapy (see page 16)	$10	100%	80%
Well-Child Care (see page 18)	$10	100%	Not Covered

	Preferred Provider		Regular Indemnity
Pregnancy Expenses	**Co-Pay**	**% Payable**	**% Payable**
Delivery (Physician Charges)	$100	100%	80%
Abortions (Therapeutic Only)	$10	100%	80%
Mental & Nervous Disorders *			
In-patient Basis	$100	100%	80%
Out-patient Basis	$20	100%	50%

* See page 20 for limitations and other restrictions.

PRESCRIPTION DRUG PLAN

	Network Pharmacies	Mail Order (90 day supply)
Co-Pay:	$ 5 Generic	$ 8 Generic
	$ 10 Name Brand	$ 15 Brand Name
Co-Insurance: 100%		

DENTAL PLAN

Deductible - $50 per person per calendar year (family limit $150)

I. Preventive - 80% of eligible expenses, after deductible

II. Basic - 80% of eligible expenses, after deductible

III. Major - 50% of eligible expenses (Employee and/or dependent must have been covered under the company's dental plan for a minimum of 12 months in order for Major expenses to be covered).

Maximum Benefit - $ 1,500 per calendar year per person

IV. Orthodontia - 50% of eligible expenses - Lifetime maximum $1000 (covered person must have been covered under the company's plan for 12 months).

Pre-Authorization Required for all dental services in excess of $500, or else benefits payable will be reduced by 50%.

Amended 1/1/98

MAXIMUM BENEFITS AND CO-PAYMENTS

The following services are payable at 100%:

1. Consultation expenses are covered in full for any second surgical opinions (maximum $150 per consultation). Any balance will be covered under Major Medical, subject to the calendar year deductible and 80% co-insurance. (This applies only for out of Network).

2. Outpatient surgery charges:

   - **In Network**: 100% up to the first $1000 of charges, thereafter, the regular co-payment of $10 applies.

   - **Out of Network**: 90% of the first $500 of charges, thereafter, the calendar year deductible and co-insurance applies according to the Schedule of Benefits.

3. Charges by a hospital for pre-admission diagnostic x-rays and lab tests performed within 7 days prior to scheduled surgery.

4. Outpatient charges by a birthing center for the delivery(ies) of baby(ies) are covered in full.

The co-insurance percentage under the Regular Indemnity Plan (Out of Network) is 80% of the first $5,000 and 100% thereafter up to the maximum.

The maximum lifetime benefit while covered under this Plan is $2,000,000 per person.

The calendar year Out-Of-Pocket Maximum for Out-of-Network covered medical benefits not including the calendar year deductible (if any), is as follows:

MAXIMUM OUT OF NETWORK CO-PAYMENT CHART

Individual	$1,000.00
Employee & Family	$2,500.00

Note: These maximums do not include the co-payments or co-insurance for Psychiatric, Private Duty Nursing Services, and Prescription Drugs.

UTILIZATION REVIEW AND CONCURRENT REVIEW PROCEDURES

Before entering a Hospital as an inpatient for any procedure or treatment, every person must contact Capp Care at #1-800-223-4276. They will pre-authorize the length of hospitalization - if required at all. Certification must be done at least 7 workdays before services are provided, except for emergency hospitalization. In the event of an emergency, the patient or Physician must call within 48 hours from the time of admission, or the first workday following a weekend or holiday admission.

Once a determination for hospitalization is made, patient records will be monitored throughout the entire Hospital stay.

If a covered person is admitted to a Hospital on a Friday or a Saturday, Hospital charges incurred on the day of admission and on the following day, if a Saturday, are not covered. This does not apply if surgery is performed within 48 hours of the admission, or the admission is due to an emergency illness or accident.

REDUCTION OF BENEFITS

Notification to the utilization review organization is mandatory for all periods of in-Hospital stay. Lack of this notification will mean:

1. Covered Hospital expenses will be reduced by 50%, which will not count towards satisfying the total out-of-pocket maximum.

2. Hospital charges for each day deemed medically unnecessary by Capp Care will not be covered and will not count towards satisfying the total out-of-pocket maximum.

COMMON ACCIDENT DEDUCTIBLE (Out of Network Only)

If two or more insured persons of a family are injured in the same accident, only one deductible will be applied to that accident. This common accident deductible will also apply to any reapplication of the deductible for that accident.

END OF YEAR CARRY-OVER (Out of Network Only)

Covered expenses incurred by a family member on or after December first, which count toward that person's deductible for that calendar year, will also count toward that person's deductible for the next calendar year. However, these expenses will not count toward the next year's family limit.

SECOND SURGICAL OPINION

1. The Plan will pay for a personal examination by a Physician following a recommendation for elective surgery.
2. When a surgeon recommends elective surgery, the covered person must obtain a second opinion as to whether surgery is the most appropriate course of treatment. If the second opinion specialist does not confirm the need for surgery, the Plan will pay for one additional consultation, if the patient so requests.
3. The Physician furnishing the second surgical opinion must not be financially associated with the original Physician (surgeon) or within the same medical group.

MANDATORY: If a second opinion is not obtained prior to the surgery being performed, the benefits will be reduced to 50% of the eligible covered charges, except in the case of an emergency.

In addition, if a second opinion is not obtained when required, the 50% payment will not count towards the maximum out-of-pocket co-payment, which is illustrated in the Schedule of Benefits.

The following surgical procedures must have a second opinion:

Cholecystectomy (unless emergency)
Colporrhaphy - Culdoscopy - Laparoscopy
Cyst Removal
Cystocele, Rectocele
Eye Surgery
1. Blepharoplasty
2. Cataract, and with lens implant
3. Corneal Transplant
4. Strabismus Correction
Frenelectomy
Gastric Bypass and Gastric Stapling
Heart (Cardiac Cath, Angioplasty, Bypass, Other)
Hemorrhoids
Hernia repair, Inguinal or Hiatal (unless strangulated) Ventral
Hysterectomy
Laminectomy
Mastoidectomy

Orthopedic Procedures Including:
1. Bunionectomy
2. Hammertoes
3. Ganglion Cysts
4. Knee Surgery (Meniscectomies, Arthroscopy, Total Knee)
5. Shoulder Surgery
6. Total Hip Replacement
Ostectomy of metatarsal heads
Pilonidal Cyst
Prostatectomy
Reconstructive Surgery
Sinusotomy
Skin Graft
Submucous resection of nasal septum
Tenotomy of toe
Thyroidectomy
Tonsillectomy (over age 21)
Transplants, all
Varicose vein excision

In addition Cosmetic Surgery is not usually a covered benefit and the patient or Physician should be referred to the benefits department of the Payor.

PREFERRED PROVIDER ORGANIZATION (PPO)

Select Pro and QualCare Preferred Providers contracts with Hospitals, medical groups and independent practice associations throughout the New York and New Jersey metropolitan areas to directly provide or manage the delivery of health care services for Plan participants. Participants may utilize the PPO network on a voluntary basis where such service is geographically available.

During the enrollment process, the Covered Employee will be provided, upon request to the personnel office, with a complete directory of all the Physicians and Hospitals that are in the Network. In addition, the Covered Employee will be issued an ID card signifying membership in **Fulton/Highpoint Chevrolet Employee Health Plan.**

The co-payments required, if using any one of the participating Physician or Hospitals, are listed in the Schedule of Benefits.

GENERAL PROVISIONS

ELIGIBILITY FOR COVERED PERSONS

The following persons will be eligible to be covered under the Plan:

Employees: All regular eligible employees in active service at their customary place of employment who work the minimum hours per week for the company, as specified in the General Information Section.

Dependents: A Covered Employee who has dependents will be eligible to enroll for dependent coverage on whichever of the following dates occurs last:

1. The date the Covered Employee is eligible for coverage, if on that date he has such dependents;
2. The date the Covered Employee gains a dependent, if on that date he is covered by the Plan.

All other persons are excluded. Employees who had been covered under the previous plan, and having fulfilled all eligibility and pre-existing condition requirements, will be covered with no waiting period.

EFFECTIVE DATE OF EMPLOYEE COVERAGE

Coverage will become effective for a Covered Employee on the date of eligibility, provided the Covered Employee is in active service on that date; otherwise the effective date will be deferred until the day following return to active service.

EFFECTIVE DATE OF DEPENDENT COVERAGE

Coverage for dependents will become effective on the same date as that of the Covered Employee, if the Covered Employee applies for dependent coverage when he/she joins the Plan, provided the dependent is not totally disabled. Otherwise the effective date of dependent coverage will be deferred until the earlier of:

a. The date immediately following the dependent's subsequent completion of a period of thirty-one (31) consecutive days without treatment after his period of disability, or
b. The date twelve (12) months following the date the dependent would have been eligible if he or she were not totally disabled.

If the Covered Employee is covered as a single employee and later acquires a dependent, he/she may enroll their dependent in this plan within thirty-one (31) days.

If coverage for a dependent is applied for more than thirty-one (31) days following the date that dependent became eligible for coverage, satisfactory evidence of insurability must be submitted. Coverage will become effective on the first of the month following underwriting approval.

TERMINATION OF COVERAGE

Coverage for the employee and/or his/her dependents will terminate under any of the following conditions:

1. When employment terminates.
2. When the Covered Employee ceases to be in an eligible class.
3. When the Plan itself is terminated.
4. When the dependent ceases to qualify as a Covered Dependent.
5. When the Covered Employee becomes a full-time member of the armed forces.
6. When the Covered Employee dies or retires.

COORDINATION OF BENEFITS

If the Covered Employee or his/her dependents are eligible to receive benefits under another group Plan, benefits from this Plan will be coordinated with your other group health plans or governmental plans, so that up to 100% of the allowable expenses incurred during a calendar year will be paid by all of the plans.

There is no coordination of benefits within the firm; i.e., both husband and wife work for ***Fulton/Highpoint Chevrolet***. Each has their own coverage, so only one employee may cover their dependents.

ORDER OF BENEFIT DETERMINATION

The rules establishing the order of benefit determination are:

When claimant is a dependent child and such child's parents are not separated or divorced, the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year, but:

1. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time or;
2. If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

PROVISIONS FOR MEDICAL CASE MANAGEMENT

The Plan Supervisor or TPA may recommend alternative care and treatment for a serious injury or illness of a covered person. Utilization of an outside agency or consultant in order to provide additional Cost Containment programs, or arrange discounts to Plan costs, are included within the Plan. This may include expenses incurred due to the recommendation of a Case Management service for providing benefits for expenses and/or an alternative treatment program not otherwise payable according to the Plan Document.

The fee which may be generated due to realizing a savings as a result of utilizing a Cost Containment program will be considered as a covered expense under the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

MEDICARE (Active Covered Persons Age 65 and Over)

All active employees age 65 and over who are eligible for coverage under this Plan, and their eligible spouse age 65 and over, will be provided with coverage on the same basis as those active Covered Employees under the age of 65, unless such employee rejects the employer provided group health Plan and elects to treat medicare as his/her only coverage. If the employee elects to retain his coverage under this Plan, then this Plan shall be treated as the primary payor for the employee and his/her eligible dependents, and medicare will be the secondary payor. The absence of any written election will construe this Plan as primary.

CONTINUATION OF COVERAGE

Federal law (COBRA - 1985) requires that the group plan allow qualified persons to continue group health coverage after it would otherwise end. For this purpose, the term "group health coverage" includes any medical, dental, vision, and prescription drug coverages that are included in the group health plan.

If a Covered Employee or his/her Covered Dependents lose eligibility under the group health plan, they may elect to extend their coverage. See the personnel manager or the person responsible for insurance benefits, within 30 days after the loss of eligibility. They will provide the necessary forms to complete, and provide premium information.

PRE-EXISTING CONDITIONS

A pre-existing condition is one in which a person has been under the care of a Physician or has received treatment, medical care, or services, including taking prescribed medication; or if there was a material manifestation of a condition that makes it readily apparent the condition existed within the 12 month period immediately preceding the effective date of the covered person's (employee or dependent) coverage under this Plan.

No payment will be made for medical charges for any pre-existing condition of the covered person (employee or dependent), until after twelve (12) consecutive months after the employee or dependent has been covered under this Plan.

These provisions apply only to employees and dependents who become covered after the effective date of this Plan, unless they have not satisfied the pre-existing condition stipulations of the plan of coverage in effect prior to the effective date of this Plan.

SUBROGATION OR ACTS OF THIRD PARTIES

In the event that the covered employee and/or his/her dependent is ill or injured in any accident which is the fault of a third party and are paid any benefits under this Plan:

1. The covered person agrees in writing to reimburse the Plan to the extent in which benefit payments are received from a third party; and
2. The covered person will provide a written lien directing reimbursement of any medical payments to the Plan Supervisor.

DEFINITIONS

BIRTHING CENTER

A licensed free standing facility, other than a regular Hospital, which provides for the delivery of one or more children. The center must have:

a) An established relationship with at least one regular Hospital.
b) Be licensed in the state where it maintains its office(s).
c) Employ a minimum staff of personnel to provide 24 hour nursing services by either registered nurses or certified midwives.

COVERED DEPENDENT

(i) An employee's lawful spouse who is not legally separated from the employee and is not a member of the armed forces, and
(ii) An employee's child who meets all of the following conditions:

A. Is a resident of the same country in which the employee resides;
B. Is unmarried;
C. Is not a member of the armed forces;
D. Is a natural child, step-child, legally adopted child or foster child up to age 19 years old (birthday), or who is at least 19 years, but less than 23 years (birthday), who is dependent upon the employee for support and who is registered for full-time (12 units) attendance at an accredited college or university; except that the maximum age limit does not apply if the child is mentally retarded or physically handicapped beyond the age of 19.

COVERED EMPLOYEE

A person directly employed full-time in the regular business of, and compensated for services by, the employer, working not less than the minimum number of hours per week, as specified in the General Information Section (page 29), and who satisfies the eligibility requirement.

HOSPICE

"Hospice" means an agency that provides counseling and medical services, and may provide room and board to a terminally ill individual, and which meets all the following tests:

A. It is licensed, and has obtained the necessary state or governmental certificate of need approval.

B. It has a full time administrator, licensed service coordinator, a registered nurse as nursing coordinator, and is under the direct supervision of a Physician.

C. It provides service 24 hours a day, 7 days a week, and maintains written records of services provided to the patient.

HOSPITAL

An institution for the care of the sick or injured, which is properly licensed or permitted legally to operate as such, and which has licensed graduate registered nurses on duty twenty-four hours a day, a "Physician" on call at all times, and facilities for diagnosis of illness, and for major surgery.

LEAVE OF ABSENCE

A period of time for which the employee has obtained in advance an approved leave of absence, including an absence under the Family and Medical Leave Act, from the employer as provided for in the planholder's company rules, policies, procedures and/or practices.

MEDICAL CHILD SUPPORT ORDERS (MCSOs)

Any judgement, decree, order, or settlement agreement issued by a court of competent jurisdiction which:

a) provides for child support with respect to the child of a participant, or provides for health benefit coverage to such child; or,

b) enforces a law related to medical child support under Section 1908 of the Social Security Act with respect to the Plan.

PHYSICIAN

A duly licensed Doctor of Medicine (M.D.), Osteopath, Dental Surgeon, Optometrist, Ophthalmologist, Psychologist (Ph.D.), Psychiatrist, Podiatrist, or Chiropractor, or any other practitioner including licensed clinical social workers or marriage, family or child counselors, [authorized by an M.D.] who provides a covered service acting within the scope of his/her license, who is required to be recognized by an applicable law.

PRE-ADMISSION TESTING

X-ray and lab exams made in contemplation of, and within seven days of a scheduled surgery, which is performed within 48 hours following the individuals admission to the Hospital.

THERAPY SERVICES

Therapy Services mean the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness. The following therapies require pre-approval:

a. Chelation Therapy - means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

b. Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents.

c. Dialysis Treatment - the treatment of an acute renal failure or a chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

d. Radiation Therapy - the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.

e. Respiration Therapy - the introduction of dry or moist gases into the lungs.

f. Cognitive Rehabilitation Therapy - the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, surgery, or previous therapeutic process, or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.

g. Speech Therapy - treatment for the correction of a speech impairment resulting from Illness, surgery, Injury, congenital anomaly, or previous therapeutic processes.

h. Occupational Therapy - treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

i. Physical Therapy - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss of limb.

j. Infusion Therapy - the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

TOTAL DISABILITY

The inability of a person to perform the substantial and material duties of that person's occupation for a period of 5 years; thereafter, the ability to perform the duties of any gainful occupation for which the person may be reasonably suited by education, training or experience.

USUAL CUSTOMARY AND REASONABLE CHARGES

The amount normally charged by a provider for a given procedure, service, medicine, or supply. These charges must be within the range of fees charged by most providers in a given geographical area (zip codes) for this same procedure, service, medicine, or supply, and taking into consideration unusual circumstances involving medical complications requiring additional time, skill and experience.

COVERED MEDICAL EXPENSES

The term "covered expenses" means the expenses actually incurred by or on behalf of you or your dependent, but only if the expenses are incurred after you or your dependent becomes covered for medical expenses, and only to the extent that the services or supplies provided are recommended by a Physician and are indicated for the necessary care and treatment of the illness or injury.

The covered expenses shall be deemed to have been incurred on the actual date the service is rendered.

1. Room and board in a Hospital, but covered expenses will not exceed the Hospital's average daily semi-private room rate.
   a) Intensive care unit is limited to 2 times semi-private room rate.
   b) A panel Hospital may not charge more than what the plan allows, but in any case, any extra cost ill not be borne by the covered person.

2. All necessary medical services and supplies for the treatment of the patient in a Hospital; including unreplaced blood and blood plasma.

3. Charges made by a Hospital or ambulatory surgical center, on its own behalf, for outpatient medical care and or surgery.

4. Charges for professional ground transportation (ambulance) and professional services (within the continental U.S., Canada, or Mexico), to transport the patient to and from the nearest Hospital where medical care and treatment necessary for the individual can be provided.

5. Charges for medical care and treatment and/or surgery performed by a Physician.

6. Charges for an assistant surgeon who is required to render technical assistance to an operation will be covered at the same percentage as the surgeon, as listed in the Schedule of Benefits.

7. Anesthesia, including the charge for administration.

8. Diagnostic laboratory and x-ray services.

9. Casts, splints, trusses, braces, artificial limbs, artificial eyes, and other prosthetic devices that take the place of actual parts of the persons body; and the rental of oxygen equipment necessary for the treatment of the patient.

10. X-Ray treatments, X-Ray examinations, radiation treatment, radioisotope treatments from non-sealed sources, including chemotherapy when such treatment is recommended by the attending Physician.

11. Initial pair of glasses, contacts, or lens implant required after cataract surgery.

12. Skilled nursing services prescribed for outpatients by the attending Physician, and provided by or under the supervision of a registered graduate nurse (RN) or, for the services of a licensed practical nurse (LPN), by one who does not ordinarily reside in the same home, and other than a member of the covered persons' immediate family, is limited to 50% of all charges with a maximum payment of $5,000 per person per calendar year. Charges by the same nurse for more than one 8 hour shift during any day are not covered. In addition, the out-of-pocket limitation does not apply to covered expenses for nursing expenses.

13. The rental, or at the Plan Sponsor's option, the purchase of wheel chairs, special Hospital beds, iron lung and other durable medical as well as mechanical equipment.

    a) As to such rented equipment, the rental period shall not exceed 6 months unless it is a wheelchair or life sustaining equipment. If obtained through a Network supplier, there will be a $10 co-payment for each month.
    b) As to purchased equipment, coverage includes the necessary repairs and maintenance that are not covered by a warranty of the maker or seller. If purchased through a Network supplier, there will be a $50 co-payment for each item.

14. Convalescent care furnished by an extended care facility for room, board and other services, after a minimum of three (3) days Hospital confinement as an inpatient, and occurring within fourteen (14) days after Hospital discharge, and is limited to 60 days per calendar year. For an out of Network facility, the Plan will pay no more than 50% of the covered daily room and board charge made by the Hospital during the covered person's preceding Hospital confinement.

15. Physiotherapy rendered by a registered physical therapist, [or speech therapy by a registered speech therapist, or cognitive and occupational therapy] is limited to 90 days (or visits) per calendar year, and payable according to the Schedule of Benefits unless plan receives a statement of medical necessity by attending Physician. Treatment rendered must be other than one who ordinarily resides in the patient's home, or who is a member of the patient's immediate family, and provided such treatment is recommended by the attending Physician.

16. Charges for services rendered in an approved birthing center, including legal midwife services, a registered midwife nurse, acting within the scope of his/her license within the state services are rendered.

17. Routine care of a newborn child while confined in the Hospital (Neo-Natal Care) is limited to the first 7 days after birth, or before the mother is discharged from the Hospital, if earlier.

    - Hospital charges for services rendered for mother and newborn child are covered.

18. All necessary services, supplies and/or charges for preventive tests as follows:

    a) Pap smear tests are limited to one (1) per year unless the Physician recommends more frequent testing.
    b) Proctological exams (including sigmoidoscopy and colonoscopy) are limited to one (1) procedure per year for diagnostic purposes unless deemed medically necessary.
    c) GYN exams are limited to once every 12 months.
    d) Mammogram - see limits on page 17.

19. The purchase of supplies required due to a colostomy or ileostomy.

20. Charges for treatment of hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation or autistic diseases of childhood.

21. Charges for treatment of allergies, including injections, will be limited to 26 visits in any 12 consecutive month period. The co-payment will be waived if the Physician does not make a separate charge for the office visit.

22. Hospital charges for therapeutic abortions only, will be treated as any other illness.

23. Benefits are payable for charges due to tissue transplants, organ transplants or replacement of tissue or organs, whether natural or artificial replacement materials or devices are used; and all charges due to complications arising from such procedures or treatment.

REPLACEMENT OF ORGANS OR TISSUE

A. The following procedures are payable on the same basis as any other illness:
   1. Cornea, kidney, bone marrow and artery or vein transplants
   2. Heart valve and joint replacement
   3. Prosthetic by-pass or replacement vessels
   4. Implantable prosthetic lenses in connection with cataracts.

B. Heart, lung, and liver transplant procedures are payable on the same basis as any other illness, but only up to a lifetime maximum of the policy, or $100,000, whichever is less. This maximum applies for each type of procedure, and to all charges incurred as a result of the transplant(s).

C. No other replacement of tissue or organs is covered.

MAMMOGRAPHY SCREENING

The Plan will pay benefits for charges for a mammography as a result of a Physician's referral for screening or diagnostic purposes. The benefits will be covered according to the Schedule of Benefits and paid on the same basis that benefits would be paid for treatment of a sickness, subject to the following provisions:

1. A mammogram at any age for covered persons having a prior history of breast cancer or whose mother or sister has a prior history of breast cancer, if the test is recommended by a Physician.

2. One baseline mammography examination for women age 35 through age 39;

3. One mammography examination every 2 years for women age 40 through age 49;

4. An annual mammography examination for women age 50 and older.

However, if recommended by the patient's Physician, additional medically required examinations will be covered.

The provisions of this section will not limit the benefits which are payable by other sections of this booklet.

ROUTINE HEALTH AND WELL-CHILD CARE

Routine health check-ups or physical examinations are covered and payable according to the Schedule of Benefits, subject to the following limitations:

In Network: All visits to a Network provider are payable at 100% as listed in the Schedule of Benefits.

1. The following limitations apply for physical examinations:

   Age 6 - 12: once every 2 years
   Age 13 - 29: once every 5 years
   Age 30 - 39: once every 4 years
   Age 40 - 49: once every 3 years
   Age 50 & up: once every year

2. Charges for well-child care, including routine physical exams, immunizations, tests and laboratory services normally done with such exams, for all covered dependents up to Age 6 are covered (by a Network Physician), and payable according to the Schedule of Benefits.

HOSPICE CARE

Benefits will be paid according to the Schedule of Benefits if a covered person incurs charges for services and/or supplies furnished by a hospice if the person's Physician certifies that the person is terminally ill and is not expected to live more then 6 months.

Covered hospice charges will be payable at the appropriate co-payment or percentage as stated in the Schedule of Benefits up to a limit of $1,500 per month, and include:

1. Room and board, services, and supplies furnished by the hospice while the patient is confined therein.
2. Part-time nursing care by or under the supervision of a registered nurse (R.N.)
3. Home health aide services.
4. Nutrition services and special meals.
5. Counseling services by a licensed social worker or a licensed pastoral counselor.

ANY COVERED CHARGE PAID UNDER HOSPICE BENEFITS WILL NOT BE CONSIDERED A COVERED CHARGE UNDER ANY OTHER BENEFIT IN THIS POLICY.

HOME HEALTH CARE

Home health care charges are covered at the appropriate co-payment and percentage as stated in the Schedule of Benefits. If the home health care agency is not a Network provider, then the charges are limited to $100 per visit, and payable at 80% according to the Schedule of Benefits. In all cases (in/or out Network) these benefits are limited to a maximum of 90 visits during any one calendar year.

Each visit (consisting of 4 hours of health care service) by a representative of a home health care agency shall be considered as one home health care visit.

Home health care charges are covered if they are medically necessary for the treatment of an insured individual who is physically unable to self administer a prescribed treatment, and who, in the opinion of the attending Physician, would otherwise have been confined as a registered bed patient in a Hospital or skilled nursing facility provided:

a. The insured individual is under the direct care of a legally qualified Physician,
b. The plan of treatment covering the home health care is established in writing by the attending Physician prior to commencement of such treatment,
c. The plan of treatment covering home health care is certified by the attending Physician at least once every month,
d. The insured individual is examined by the attending Physician once every 60 days.

Covered Home Health Care Charges:

1. Part-time or intermittent nursing care, by either a registered nurse or a licensed practical nurse (L.P.N.),
2. Part-time or intermittent home health aide services,
3. Occupational, speech and physical therapy,
4. Social work, performed by a licensed social worker
5. Nutrition services and special meals performed by a licensed nutritionist.

Excluded Home Health Care Charges:

1. Charges for services for which the individual is not, in the absence of this insurance, legally required to pay;
2. Charges for services performed by the insured's immediate family or any person residing with the insured;
3. General housekeeping services, or custodial care.

MENTAL & NERVOUS DISORDERS

Professional treatment by a Physician or health care provider (including a licensed and approved Hospital or institution) of mental, nervous and emotional disorders (meaning a neurosis, psychoneurosis, psychopathy, psychosis or functional nervous disorder of any type), will be a covered expense and payable at the appropriate percentage as stated in the Schedule of Benefits.

1. **Inpatient** - Any confinement in an accredited or licensed Hospital or a public or private facility providing services especially for mental illness, and which is licensed by the Department of Public Health for that purpose, will be considered on the same basis as any other illness, subject to an annual limit 30 days, and will be payable according to the Schedule of Benefits.

2. **Outpatient -**
   a) **In Network:** There is a maximum of 26 visits per person per calendar year at the stated co-payment listed in the Schedule of Benefits.
   b) **Out of Network:** Treatment charges are limited to 50% of eligible charges per visit, with a calendar year maximum limit of 26 visits per person per calendar year, and will be payable according to the Schedule of Benefits.
   c) These out-patient limitations will not apply to the professional administration of convulsive therapy.

Other Limitations:

1. All covered charges must be performed personally by a Physician (MD), or a licensed clinical social worker (LCSW), a marriage family and child counselor (MFCC), or a licensed or certified Psychologist, as long as the provider is licensed and authorized to perform those services according to the state law in which the services are performed.

Amended: 1/1/98

PREGNANCY EXPENSE BENEFIT

Expenses for medical care or treatment that is due to pregnancy, and that the Covered Employee or his/her dependent incur while covered, will be considered covered benefits. Such benefits shall be subject to all the same terms and conditions as apply to care and treatment of a disease, and payable according to the Schedule of Benefits.

1. Covered conditions requiring Hospital stays (when the pregnancy is not terminated) and whose diagnosis are distinct from pregnancy include: Acute nephritis, cardiac decompensation, occasional spotting, pre-eclampsia, missed abortion and similar medical and surgical conditions of comparable severity.

2. Additionally covered are non-elective Cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Conditions that are not covered are those termed medically unnecessary; i.e. false labor, Physician prescribed rest during the period of pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy.

Complications of pregnancy shall be subject to the same terms and conditions of the Group Plan as are applicable to any other disease of the covered person. This Plan will only pay for an employee or dependent's pregnancy.

SMOKING CESSATION AND WEIGHT REDUCTION

Charges, treatments or procedures for weight reduction, obesity or smoking are covered for employees only, must be ordered by a Physician, and/or approved by the Plan Supervisor in advance.

A) Approved stop smoking programs are limited to $500 per employee per calendar year, with a lifetime limit of $1000, and payable as follows:

1. 25% of the cost of the approved program will be reimbursed once the Covered Employee submits proof of enrollment.
2. An additional 40% of the cost of the approved program will be reimbursed after the Covered Employee has maintained 6 continuous months of non-smoking. The Plan Sponsor must approve this reimbursement in writing prior to submission to the Plan Supervisor (TPA).
3. Remaining 35% will be paid after 12 months of not smoking.

B) Approved weight loss programs are covered as long as the Covered Employee is 25% over the Physicians' average weight chart, based upon build, height and weight, and is limited to $500 per person per calendar year with a lifetime benefit of $1000, and payable as follows:

1. 25% of the cost of the approved program will be reimbursed once the Covered Employee submits proof of enrollment.
2. An additional 40% of the cost of the approved program will be reimbursed after the Covered Employee has lost the stipulated weight and maintained that weight for at least 3 months. The program supervisor must first signify that the Covered Employee has successfully followed the program, and then the Plan Sponsor must approve this reimbursement in writing prior to submission to the Plan Supervisor (TPA).
3. Remaining 35% will be paid as long as the employee maintains the weight loss for 9 months.
4. Covered charges include the program only and excludes food, vitamins, other dietary supplements, and liquid diets.

PRESCRIPTION DRUG CARD PROGRAM

Prescription drugs and medications, except for excluded items such as experimental drugs and vitamins are an eligible expense able to be purchased at participating pharmacies honoring the **Express Scripts** card.

In order to purchase drugs or medicines they must be lawfully obtainable with a Physician's prescription. The co-pay amount, as shown in the Schedule of Benefits, must be paid for each prescription purchased. A second ID is required to fill any prescription.

Any refill or prescription in excess of a 30 day supply may be purchased through a mail order program and is limited to a 90 day supply for each prescription. Refer to the Schedule of Benefits for the deductible amount.

If the pharmacy is not a member of the **Express Scripts** network, any charges paid for a prescription will be reimbursed directly to the employee by **Express Scripts** at the average wholesale cost plus the appropriate dispensing fee. In these cases, the **Express Scripts** reimbursement claim form should be filled out and mailed to them.

MEDICAL EXCLUSIONS AND LIMITATIONS

No payment will be made under the Plan for expenses incurred by a covered person:

1. For, or in connection with, any injury or sickness or condition for which the covered person is entitled to benefits under any worker's compensation law or occupational disease law or similar law;

2. In a facility owned or operated by the United States or any state or local government;

3. To the extent that payment under the Plan is prohibited by any law of the jurisdiction in which the covered person resides at the time the expenses are incurred;

4. For charges which the covered person is not legally required to pay or for charges which would not have been made if no coverage had existed;

5. For charges made which are in excess of Usual, Customary and Reasonable charges, or for charges for unnecessary care or treatment;

6. For charges or services and supplies when not under the regular care and treatment of a Physician or licensed practitioner, nor charges by a Hospital if confinement is not recommended and approved by a Physician;

7. For the treatment of injury sustained or sickness contracted while on duty with any military, naval or air force of any country or international organization, or in any war, declared or undeclared.

8. For cosmetic surgery, except for treatment by a Physician commencing within three months following an injury resulting from an accident sustained while covered; and except to correct a congenital anomaly in a child born while the covered person is covered under the Plan with respect to dependent coverage; and except for a one time reconstructive surgery, if medically prescribed, following a mastectomy.

9. Charges for experimental procedures or investigational treatments, screening or research studies, and including drugs, biological products or medical devices;

10. Charges of any resident Physician or intern of a Hospital or charges rendered for treatment of a covered person by a member of the covered person's family related by blood or marriage;

11. To the extent that the covered person is reimbursed, entitled to reimbursement, or in any way indemnified for those expenses by or through any public program (including but not limited to Medicare);

12. No benefits shall be payable for any injury or sickness as to which the covered person shall fail to provide full information, or to permit full examination, reasonably required for confirmation of entitlement to such payments;

13. Charges related to radial keratotomy for the correction of nearsightedness;

14. Charges for eye exams, eyeglasses, contact lenses and other vision or hearing aids, or examinations for fitting of eyewear or hearing aids.

15. Charges incurred for any intentionally self-inflicted injury or illness;

16. Charges for items of personal comfort unless deemed medically necessary by the attending Physician and approved by the Plan Supervisor;

17. Charges incurred for non-emergency services performed outside of the U.S.A., or for regular medical care after the first 90 days of a trip outside of the U.S., for those covered persons living in the U.S.;

18. Charges for any loss or expense resulting from any covered person's engaging in or attempting to engage in an illegal occupation or participation in a riot, or in the commission of a crime, directly or indirectly;

19. There is a limit of two specialist consultations per illness, with an overall annual limit of 5 visits per calendar year, excluding second surgical opinions;

20. No benefits shall be payable for the treatment of voluntary sterilization (male or female), infertility services, reversals of voluntary surgical induced infertility, artificial insemination, embryo and fetal implants, counseling regarding family planning, or charges arising from or related to invitro (test-tube-baby) expenses other than maternity delivery;

21. Charges for Chiropractic Care;

22. Charges for thermograms, herbal treatments, acupuncture or for services related to hypnotism, or for treatment by a Christian Science Practitioner or Pastoral Counselor in course of his normal duties as a religious Minister;

23. No payment will be made for medical expenses arising from vehicular accidental injury to the extent that these expenses would otherwise qualify for payment under the personal injury protection (P.I.P.) provisions of personal automobile insurance, if such coverage was available to the claimant at his option, regardless of whether such coverage was actually in force;

24. Any medical charges, services or supplies related to the diagnosis or treatment of temporomandibular joint dysfunction syndrome (TMJ) either by a Physician or a dentist;

25. Charges for dental care or treatment except by a Physician, dentist or Dental Surgeon within 3 months following an injury to the jaw or natural teeth resulting from an accident sustained while covered under this plan;

26. Supplies related to methadone maintenance or treatment;

27. Charges and/or expenses for routine foot care or for orthopedic shoes or other supportive appliances for the feet;

28. Wigs, toupees, hair transplants, hair weaving or any drugs relating to baldness;

29. Self-administered services such as biofeedback, patient controlled analgesia on an outpatient basis related to diagnostic testing, self care and self help training;

30. Medical charges (Hospital or Physician) for a sex change operation;

31. Charges for the treatment of substance abuse and alcoholism;

32. There will be no coverage for services or supplies not specifically stated under the Schedule of Benefits.

COVERED DENTAL EXPENSES

Class I: Preventive Expenses - payable at 80% - after deductible

1. Examinations and office visits
    a. Prophylaxis - including scaling and polishing (limit once every 6 months)
    b. Routine oral exam (limit once every 6 months)
    c. Fluoride treatment for children under age 15 (limit once every 6 months)

2. X-rays and Pathology
    a. Full mouth series (limit once every 2 years)
    b. Bitewing (limit once every 6 months)
    c. Periapical
    d. Occlusal (limit once in any 2 year period)

Class II: Basic Expenses - payable at 80% - after deductible

1. Endodontics treatment
    a. Root canal therapy, pulpotomy, apicoectomy, and retrograde filling.

2. Single Extractions

3. Oral surgery
    a. Extraction of one or more teeth and/or tooth root
    b. Alveolectomy, alveoplasty, and frenuelectomy
    c. Excision of pericoronal gingiva, exostosis or tissue for biopsy
    d. Re-implantation of a natural tooth.
    e. Excision and/or drainage of a tumor, cyst or abscess

4. Periodontics treatment
    a. Prophylaxis (limit once every 6 months)
    b. Root seeding (once per quadrant every 6 months)
    c. Occlusal adjustment (only if performed with periodontal surgery)

5. Study models (limit once in any 3 year period)

6. Crown build-up on non-vital teeth

7. Pin retention of fillings

8. Restorations

9. Recementing inlays, onlays, crowns and/or bridges

10. Repairs to full or partial dentures (limit once in any 3 year period)

11. General anesthetics in connection with oral surgery

12. Antibiotic injections administered by the treating dentist

Class III: Major Expenses - payable at 50% - after deductible

Limited to employees and/or their dependents who have been covered for 12 months.

1. Major periodontal treatment
   a. Gingivectomy
   b. Osseous surgery
   c. Pedicle or free soft tissue grafts
   d. Periodontal appliances (limit once in any 5 year period)

2. Restorative services and supplies
   a. Gold or porcelain inlays, onlays and crowns (if necessary only)
   b. Replacement of existing inlays, onlays or crowns (limit once in any 5 year period)
   c. Stainless steal crowns
   d. Post and core

3. Prosthetic services and supplies
   a. Initial placement of full or partial dentures or fixed bridgework
   b. Replacement of full or partial dentures or fixed bridgework (limit once in any 5 year period)
   c. Addition of one or more teeth to an existing partial denture
   d. Relining or rebasing of existing removable full or partial denture (limit once in any 5 year period)

Class IV: Orthodontia Expenses - Payable at 50%

Limited to employees and/or their dependents who have been covered for 12 months.

1. Preliminary study including x-rays, diagnostic casts and treatment plan and first month of active treatment including all active treatment and retention appliance

2. Active treatment per month after the first month

3. Fixed or cemented appliances
   a. For tooth guidance - one arch per person
   b. To control harmful habits - one appliance per person

Orthodontia Provision: Payment of benefits will be made every three months:

First Installment - after appliance is installed
Later Payments will be payable at the end of each three month period.

Maximum Benefit $1000 per person for Orthodontia.

PRE-AUTHORIZATION OF DENTAL TREATMENT

A covered person must submit a pre-authorization for all dental services in excess of $500 before treatment commences, or benefits will be reduced by 50%. The only exception to this rule is for emergency treatment.

DENTAL EXCLUSIONS AND LIMITATIONS

No payment will be made under the Plan for expenses incurred by a covered person for:

1. Services furnished by the U.S. government, unless payment is legally required.
2. An appliance or any modification or procedure which began prior to coverage.
3. Services due to an employment related accident or disease covered by workmen's compensation.
4. For services, treatments or supplies that have not been recommended and/or approved by a dentist or Physician.
5. A denture or fixed bridge involving replacement of teeth extracted before the Covered Employee or his/her dependent was covered, unless it also replaces a tooth that is extracted while covered, and such tooth was not an abutment for a denture or fixed bridge installed during the preceding five years.
6. Replacement of lost or stolen appliances or restorations for the purpose of splinting, or to increase vertical dimension or to restore occlusion.
7. Services for cosmetic reasons unless necessary due to an accident occurring while covered.
8. For charges made which are in excess of usual, customary and reasonable charges, or for charges for unnecessary care or treatment.
9. Charges for implantology.
10. Charges for sealants, oral hygiene instruction, plaque control, program or dietary instruction, unless the dentist's fee schedule normally includes charges for these services.
11. Dental care for congenital or developmental malformation.
12. Any charges, services or supplies related to the diagnosis or treatment of temporomandibular joint dysfunction syndrome (TMJ);
13. Charges for overdentures,including root canal therapy and supportive restorations.
14. Charges for completion of claim forms, or missed appointments.
15. Items intended for sport or home care.
16. Charges incurred after insurance ends; however, charges for any prosthetics (an artificial replacement of one or more natural teeth), including bridges and crowns, which were fitted and ordered prior to the date insurance ends will be covered. The covered person must receive the prosthetic device within 30 days after the insurance ends.
17. Services or supplies not included in the Schedule of Dental Benefits.

AMENDING THE PLAN

The Plan Sponsor has the option at any time to amend the plan of benefits, as long as any changes made are not discriminatory, and the employees are notified 30 days prior to any change.

RIGHTS OF COVERED EMPLOYEES

As a participant in the Employee Health Care Plan, each Covered Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

a) A review of the eligibility status for any claims by the Plan Supervisor.
b) May request from the Plan Supervisor a review of any claim payments.
c) Must file requests for review in writing to the Plan Supervisor, stating in clear and concise terms the reasons for disagreement.

HOW TO FILE A CLAIM

MEDICAL CLAIMS (Out of Network Only): Employees are required to submit complete billings from providers using the standard forms or similar billing format. Such billing must have information sufficient to determine the eligibility of the submitted expense, and include:

a) Name of covered person
b) Name of patient
c) Procedure codes
d) Diagnosis codes
e) Date of service
f) Charges
g) Name of Provider

DENTAL CLAIMS: Dental claim forms may be obtained from the personnel office, and should be submitted to the Third Party Administrator listed below. Employees are required to complete the "Employee" section on the dental claim form and give it to their dentist's office. It is necessary to do this each time the Covered Employee or Covered Dependent(s) see the dentist. It is customary for the dentist's office to complete the remainder of the claim form.

Originals of all bills should be submitted to the Plan Supervisor (TPA) at:

The W. J. Jones Companies
1979 Marcus Avenue, #C101
Lake Success, NY 11042
(800) 831-7783
(516) 775-5420

Any Hospital, Physician, or Dentist requiring additional information other than that which shows on the forms and your I.D. card should be referred to W.J. Jones at the above address.

SUMMARY PLAN DESCRIPTION

This Summary Plan Description has been prepared in compliance with Public Law 93-406, better known as the "Employee Retirement Income Security Act of 1974" (ERISA). The information furnished herein is designed to acquaint you with the benefits of your Plan which are now available to you and your covered eligible dependents.

GENERAL INFORMATION

Name of the Plan:	Fulton/Highpoint Chevrolet Employee Health Care Plan
Plan Sponsor/ Agent for Service of Legal Process:	Fulton/Highpoint Chevrolet P.O. Box 519 Middletown, NY 10940 (914) 343-3184
Employer Identification Number:	# 13-3050409
Plan Effective Date:	April 1, 1997
Plan Supervisor & Third Party Administrator:	W.J. Jones 1979 Marcus Avenue, #C101 Lake Success, NY 11042
Sources of Contribution:	Dependent coverage is contributory.
Minimum Work Week Requirements:	Average 30 hours a week.
Dependent Children's Coverage:	Unmarried children covered up to age 19, and through age 23, if a dependent and a full time student.
Waiting Period for Eligibility:	1st of the month following 30 days of work.
Coverage Termination Date:	The last day of the month in which employment ended.

The requirements for being covered under this Plan, the provisions concerning termination of coverage, a description of the Plan benefits (including any limitations and exclusions), the procedures to be followed in presenting claims for benefits, and remedies available for redress of claims denied are shown on the preceding pages of this booklet.